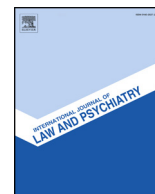




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“It's about how much we can do, and not how little we can get away with”: Coronavirus-related legislative changes for social care in the United Kingdom[☆]

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ABSTRACT

The coronavirus pandemic, referred to here as Covid-19, has brought into sharp focus the increasing divergence of devolved legislation and its implementation in the United Kingdom. One such instance is the emergency health and social care legislation and guidance introduced by the United Kingdom Central Government and the devolved Governments of Wales, Scotland and Northern Ireland in response to this pandemic. We provide a summary, comparison and discussion of these proposed and actual changes with a particular focus on the impact on adult social care and safeguarding of the rights of citizens. To begin, a summary and comparison of the relevant changes, or potential changes, to mental health, mental capacity and adult social care law across the four jurisdictions is provided. Next, we critique the suggested and actual changes and in so doing consider the immediate and longer term implications for adult social care, including mental health and mental capacity, at the time of publication. Several core themes emerged: concerns around process and scrutiny; concerns about possible changes to the workforce and last, the possible threat on the ability to safeguard human rights. It has been shown that, ordinarily, legislative provisions across the jurisdictions of the UK are different, save for Wales (which shares most of its mental health law provisions with England). Such divergence is also mirrored in the way in which the suggested emergency changes could be implemented. Aside from this, there is also a wider concern about a lack of parity of esteem between social care and health care, a concern which is common to all. What is interesting is that the introduction of CVA 2020 forced a comparison to be made between the four UK nations which also shines a spotlight on how citizens can anticipate receipt of services.

1. Introduction

Legislation as it affects adult health and social care in the four devolved jurisdictions of the United Kingdom (UK) has developed, progressed and been modified through a gradual process of evolution. For example, reforms to the current mental health legislation that each jurisdiction implements have resulted from lengthy consultation processes to meet new policy initiatives and imperatives to promote people's rights to autonomy but also to protect the public and society. The rapid introduction of the Coronavirus Act 2020 (CVA 2020), and the Coronavirus (Scotland) Act 2020 (CV(S)A 2020) which gained Royal Assent on 25th March 2020 and 6th April 2020 respectively, and the Coronavirus (Scotland) (No.2) Act (CV(S)(No.2)A 2020, which became law on 26th May 2020, is therefore markedly different. Drafted by the Westminster Government in conjunction with the devolved

governments and progressed rapidly through the respective Parliaments at a time of an international public health crisis, CVA 2020, CV(S)A 2020 and CV(S)(No.2A) 2020 temporarily amend the usual legislation. Depending upon the jurisdiction, their implementation varies (see, sections 93–96 CVA 2020). The CVA 2020 can remain in force within a period of two years from its enactment, although this can be extended (see section 89) country by country as needed. (See [Tables 1–5](#).)

The introduction of such powers gives rise to several key questions: what is the rationale for such emergency measures; who do these amendments help or do they hinder; how accountable and transparent are they; and, last, what does their rapid introduction reveal about the democratic policy process?

What follows first is a narrative comparison and summary of the changes for each jurisdiction, factually. It should be noted that the focus for mental health is on the application of the mental health law to

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Table 1
Summary of potential changes: mental health law.

	Implications of detention decisions - less doctors	Community treatment orders	Doctors and nurses holding powers	New Roles
England	Yes	No	Yes	No
Wales	Yes	No	Yes	No
Scotland	Yes	Yes	Yes (Nurses)	No
Northern Ireland	No	Not applicable	Yes	Relevant social worker and relevant medical practitioner

Table 2
Modified timescales for nurses and doctors holding powers.

	Original nurse's holding power	Modified nurse's holding power	Original doctor's holding power	Modified doctor's holding power
England	6	12 h	72	120
Wales	6	12 h	72	120
Scotland	3	6 h	72*	120*
Northern Ireland	6	12 h	48	120

* an EDC which can be used in hospital and in the community.

Table 3
scrutiny across the four nations.

	Quality assurance	Data collection and scrutiny
England	Care Quality Commission Mental Health Act Reviewers	NHSDigital
Wales	Care Inspectorate Wales	NHS Wales Informatics Service for Wales
Scotland	Mental Welfare Commission for Scotland (MWC) and Scottish Ministers	Mental Welfare Commission for Scotland (MWC) and Scottish Ministers
Northern Ireland	Regulation and Quality Improvement Authority (RQIA)	RQIA, the Health and Social Care Board (for delegated statutory functions) and the Information and Analysis Directorate, Department of Health

Table 4
Summary as to whether the usual scrutiny by quality assurance agencies is sufficient during times of emergency legislation.

For England & Wales - none of the above quality assurance agencies has a remit for regulating the Approved Mental health Professionals decision making under the MHA and scrutinising whether the CVA 2020 provisions or the usual provisions under the MHA 1983 are being used appropriately.

For Scotland - the MWC requires practitioners to detail where any modifications have been used in statutory forms. It has also established a 'scrutiny group', made up of key stakeholders from the statutory and third sector that would be operationalised should the measures under CVA 2020 be commenced (MWC, 2020). Scottish Ministers are also required to review and report on the operation of the provisions of the CVA 2020, the CV(S)A 2020 and the CV(S)(No.2)A 2020 every two months.

For Northern Ireland - the Health and Social Care Trusts are required to monitor and evaluate the appropriateness, on a case by case basis, of each use of the relevant modifications to the MH(N)O, 1986 and the MCA(NI), 2016 and then provide a report of every use and its appropriateness to the Department of Health (NI) within a set time

Table 5
Professionals Registered in England.

Doctors	Approx. 206,620 (GMC 2018)
Nurses	Approx 518,980 (NMC 2019)
Social Workers	Approx. 100,000 (Social Work England, 2019)
Approved Mental Health Professionals	Approx. 5000 across (ADASS, 2018)

restrict movement and/or deprive liberty and not operational procedures for secondary mental health services per se. Next we discuss several core themes: process and scrutiny of legislative change; work-force; threat to human rights; and a wider concern about a lack of parity of esteem between social care and health care.

2. Legislative changes and related guidance

CVA 2020 allows for the temporary modification of the law in the jurisdictions of England, Wales, Scotland and Northern Ireland. For the purposes of this article we will begin with section 10 which introduces four schedules to modify the civil mental health and mental capacity legislation, namely England and Wales (Schedule 8), Scotland (Schedule 9) and Northern Ireland (Schedules 10 & 11). Comments will also be made on the CV(S)(No.2)A2020 and CV(S)A 2020. We later cover sections 15 (with Schedule 12) for England and Wales and section 16 for Scotland in respect of local authority adult social care and support.

2.1. Mental health law – potential changes to roles, time limits and other safeguards

The changes introduced by CVA 2020 (and CV(S)(No.2)A 2020) relate predominantly to requirements regarding roles, time limits and safeguards. These changes were informed by prior emergency planning for a pandemic that sought to mitigate the risk of a significant proportion of health, social care staff and other professionals succumbing to illness (For example, see [Royal College of Psychiatrists Scotland, 2019](#)). As such, while the relevant legal tests for the use of compulsory mental health measures have not been altered, the amount of evidence and number of people required to provide it have, along with changes to some time limits and safeguards for certain measures.

In England and Wales, under the Mental Health Act 1983 (MHA1983), the changes are as follows: an application for detention under section 2 (admission for up to 28 days for assessment) or section 3 (admission for up to six months for treatment) should still be made by the usual applicant, in this case an Approved Mental Health Professional (AMHP). However, this application could, if implemented, be founded upon a single medical recommendation and not, as is usual,

two. In addition, there is no requirement for the doctor to have any previous acquaintance with the person. Both changes can only be utilised if the process of gaining a second doctor would constitute 'undesirable delay' or be 'impractical' (Schedule 8, Part 2, 3(1)).

Currently, numerous timescales appear in the MHA 1983. One is the length of time a person can be held under section 135 or section 136 (using police powers to move to a place of safety for assessment). Under CVA 2020 these timescales can be extended from 24 to 36 h with the usual extension of twelve hours if clinically indicated. Other holding powers have also been extended: a mental health or learning disability nurse who wants to prevent a patient from leaving an inpatient ward until reviewed by a doctor, can now do so for up to twelve hours, an increase from six. Meanwhile, the equivalent doctor's holding power has also been extended, from up to 72 which is the norm, to 120 h. In usual circumstances, the report needed to authorise this holding power must be provided by the patient's own Approved Clinician. Under CVA 2020 any Approved Clinician or doctor can authorise this holding power.

In relation to other safeguards, the requirement to gain an independent medical certificate under section 58 (which allows a detained person to be treated beyond three months without their consent and is ordinarily provided by a Second Opinion Approved Doctor (SOAD)), can now be provided by a non SOAD, such as the patient's own Approved Clinician, if it would meet the same 'undesirable delay' or 'impracticability' criteria under Schedule 8 as previously indicated. In addition, the non-SOAD would also only need to consult with just one other professional, rather than the usual two. Notably there has been no amendments to the provisions for section 17A Community Treatment Orders (CTOs) in England and Wales.

CVA 2020 also makes a number of modifications to Part 3 of the MHA 1983, which deals with people with a mental disorder in the criminal justice system. For example, the courts would be able to rely on a single medical recommendation (rather than two recommendations, as currently is the case) to order detention in hospital of an accused person or offender, again if seeking a second recommendation would be "impractical or would involve undesirable delay".

Most of the modifications to the MHA 1983 have not yet been brought into force. The only exception is in Wales, where the CVA 2020 (Commencement No 1) (Wales) Regulations 2020 have made certain temporary changes (as from 27 March 2020) to the constitution and hearings of the Mental Health Review Tribunal for Wales. This allows for, for example, single members panels or two member panels, and cases to proceed without a hearing. In England, similar modifications to the First-tier Tribunal (Mental Health) have not required the CVA 2020 but have been made through amendments to the Tribunals, Courts and Enforcement Act 2007, judicial guidance and practice directions (e.g. the Tribunal Procedure (Coronavirus) (Amendment) Rules 2020 which amongst other matters allows for cases to be disposed without a hearing and remote hearings).

In **Scotland**, the temporary modifications introduced by CVA 2020 and the CV(S)(No.2)A 2020 to the Mental Health (Care and Treatment) (Scotland) Act 2003 (MH(S)A 2003) and the Criminal Procedures (Scotland) Act, 1995 (CP 1995) are similar in nature to those indicated for other jurisdictions. As in England and Wales, these are not in use at the time of writing and would need to be commenced by Scottish Ministers if and when required.

Timescales for detention have been increased, with an Emergency Detention Certificate extended from 72 to 120 h. Similarly, the prescription on the use of back-to-back Short Term Detention Certificates, which last for up to 28 days, has been suspended, allowing for two to run consecutively. In this, the Approved Medical Practitioner (AMP), (the equivalent to the Approved Clinician in England and Wales and the Part II Doctor in Northern Ireland), may forgo the requirement to obtain the consent of a Mental Health Officer (MHO) (the equivalent of an Approved Mental Health Professional in England and Wales and an Approved Social Worker in Northern Ireland) again if "impractical" or if

this would involve "undesirable delay". A nurse's holding power has also been extended, in this case from three to six hours.

Other safeguards relating to longer-term compulsory measures are also amended, for example, allowing an MHO to make an application for a Compulsory Treatment Order (hospital or community) under the MH(S)A 2003 lasting up to six months on the basis of one rather than two medical reports, again where it would be impractical or involve undesirable delay. Relatedly, rules regarding medical treatment under the MH(S)A 2003 have also been temporarily relaxed. This allows a Responsible Medical Officer (equivalent to a Responsible Clinician in England and Wales and a Responsible Medical Officer in Northern Ireland) to administer medication after the prescribed two month period without having sought a second opinion from a Designated Medical Practitioner (equivalent to the SOAD in England and Wales) and as long as the request for such an opinion has been made and to wait would cause undesirable delay. There are similar modifications to criminal measures pertaining to 'mentally disorder offenders', including an extension of Assessment Orders from the current fourteen days to twelve weeks.

In addition, a number of other safeguards would be relaxed if measures under CVA 2020 were commenced. These include the suspension of conflict of interest rules relating to AMPs examining the 'patient'. If implemented, the AMP can be in a supervisory relationship with the other examining medic and work in the same NHS or independent hospital where the patient is being treated. Also, the Mental Health Tribunal Scotland (MHTS) can hold hearings with two rather than three Panel members. Moreover, MHTS can decide a case without an oral hearing against the wishes of a patient, in which circumstances the patient or other relevant parties are entitled to make written submissions before a decision is reached.

In Scotland, the CV(S)(No.2)A 2020 has also introduced two measures to amend the MH(S)A 2003 and CP(S)A 1995 with immediate effect. Schedule 1, section 12 removes the requirement to have a named person's signature to undertake acceptance of the named person role witnessed by a prescribed professional. The named person was introduced by the MH(S)A 2003 and replaced the nearest relative. It is seen as an important safeguard for patients, the alteration being designed to ensure it is not invalidated by access issues related to Covid-19. Schedule 2, section 1 removes the three week time limit on accused persons remanded for inquiry into their physical or mental condition where they have committed an offence punishable with imprisonment. This is aimed at enabling further time to access medical advice ([Coronavirus \(Scotland\) \(No.2\) Bill: Policy Memorandum, 2020](#)).

For Northern Ireland, Schedule 10 of CVA 2020 enables a number of temporary modifications, if necessary, to the Mental Health (Northern Ireland) Order, 1986 (MH(NI)O, 1986) including to the relevant professional roles, time limits and other safeguards. The Emergency Code of Practice ([Department of Health \(NI\), 2020](#)), which is a temporary addendum to the MH(NI)O, 1986's Code, reinforces that these modifications are only to be used when the relevant requirements of the MH(NI)O, 1986 cannot be met.

The current process for compulsory admission for assessment is that a doctor, preferably the person's General Practitioner (GP), has to complete a medical recommendation and an Approved Social Worker (ASW), or increasingly rarely, the Nearest Relative (a person designated through the MH(NI)O, 1986) has to complete an application. The person can then be conveyed to hospital where they must be assessed by a hospital doctor to determine whether admission is necessary. It is worth noting that this is the current and routine process in Northern Ireland but is very similar to the modified process for England and Wales. Schedule 10 of CVA 2020 introduces the role of a Relevant Social Worker, defined as a registered social worker with at least five years' experience of social work in the last ten. In Paragraph 3(1) of Schedule 10 it states that if "it is impractical or would involve undesirable delay for the application to be made by an Approved Social Worker" and a Relevant Social Worker "is of the opinion that an

application should be made” then they can act as applicant. The Relevant Social Worker, in addition to the application and their assessment report, must also complete a statement confirming that an ASW was not available and that they have explained their role to the person being assessed and, if practicable, their Nearest Relative. The Emergency Code of Practice also specifies that for the assessment by the doctor and ASW “alternative methods of communication such as Facetime or Skype may be considered in exceptional circumstances where an assessment of the risk involved indicates it.” (Department of Health (NI), 2020 Paragraph 16).

There are also a number of potential changes to the time limits involved in these assessment and detention processes. Under the MH(NI)O, 1986 the GP and ASW were required to have assessed the person within two days of completing the medical recommendation(s) and application. Under Schedule 10 this can be extended to up to five days. For people who are already voluntary inpatients, under the MH(NI)O, 1986, there are holding powers to facilitate assessment by the GP and ASW. The doctor's holding power time limit can now be extended from 48 h to 120 h and the nurse's holding power can be extended from six hours to twelve. If a medical recommendation and application have been completed, under the MH(NI)O, 1986, once the person is conveyed to hospital, they must be seen immediately after arrival by a hospital doctor and under Schedule 10 this can be “as soon as practicable and not later than 12 hours after.” Modifications are also possible to the initial period of admission for assessment which has been extended from up to 14 days to up to 28 days. Again, it's worth noting that the modified period of 28 days in Northern Ireland is the same as the unmodified assessment period in the other jurisdictions.

For those who may need to be further detained for treatment (initially for up to six months) Schedule 10 introduces the role of a relevant medical practitioner who may complete the examination and report if it is impractical for an approved doctor (under Part II of the MH(NI)O, 1986), as usually required, to do this. Although not the focus here, there are also a number of potential temporary modifications to the criminal justice aspects of the MH(NI)O, 1986.

A summary of the potential changes in mental health law is provided in Tables 1 and 2:

It is also worth reiterating that in Scotland detention for up to 28 days under a Short Term Detention Certificate (lasting up to 28 days) can now run consecutively under the emergency legislation. No such provision has been made for section 2 deletions (up to 28 days) in England and Wales, or admissions for assessment in Northern Ireland to run consecutively in the same way.

2.2. Mental capacity law – potential changes to roles, time limits and other safeguards

CVA 2020 does not provide for any modifications to be made to the Mental Capacity Act 2005 (MCA 2005) in England and Wales including the Deprivation of Liberty Safeguards (DoLS) contained in schedule A1. This means that these provisions will continue to apply. However, the Department of Health and Social Care has published non statutory guidance on the Mental Capacity Act and DoLS during the Covid-19 emergency. This includes guidance on when a DoLS authorisation may be needed for Covid-19 arrangements and treatment, the prioritisation of DoLS referrals, the use of previous assessments and the use of phone or video calling for assessments and reviews. There is also supplementary guidance which has been published, in the form of a Q/A, to further expand on the emergency guidance. This guidance also applies in Wales. For a discussion on the impact of the pandemic on mental capacity legislation, see Ruck Keene (2020).

Additional changes specific to Scotland are introduced by the CV (S)A 2020, Schedule 3, Part 2. This act covers a broad range of public health and welfare considerations including those relating to children and vulnerable adults and addresses capacity law in the form of the Adults with Incapacity (Scotland) Act, 2000 (AWI(S)A 2000) and

related measures under the Social Work (Scotland) Act, 1968 (SW(S)A 1968). A further difference is that some of these provisions are currently active while others have not yet been commenced.

The active changes relate to the AWI(S)A 2000 and include Guardianship Orders, a court appointment which authorises a person to act and make decisions on behalf of an adult with incapacity, usually for a period of three years. The CVA(S)A 2020 has ‘stopped the clock’ regarding the duration of Guardianship Orders currently; in other words, they will carry on and are not subject to the normal Court renewal process while the temporary legislation remains in force. For example, in the period 7 April to 21 May 2020, 150 Guardianships were due to expire and will have had the clock stopped when the provisions came into force (Scottish Government, 2020a). Similarly, section 47 certificates, which cover medical treatment for people who lack capacity to consent and may also be used to provide treatment for mental health where the patient is not objecting, have had the renewal requirement suspended and will continue until the current temporary measures are lifted. The key provision yet to be commenced relates to S13ZA of the SW(S)A 1968. S13ZA was introduced in 2007 as a way of enabling local authorities to make decisions about services for adults who lack capacity where certain conditions apply. These include where the person does not oppose the decision, either verbally or through their behaviours, and where all other interested parties, including family, carers and professionals are in agreement with the proposed care plan. Significantly, the modification to the SW(S)A 1968 removed the requirement to take into account the views of the adult and relevant parties. In addition, it would allow the local authority to use S13ZA even when Guardianships, Intervention Orders and Powers of Attorney are in place. The human rights implications of these changes are addressed in the discussion.

In Northern Ireland, the Mental Capacity Act (Northern Ireland) 2016 (MCA(NI) 2016) was partially implemented, on 2nd December 2019, for interventions involving deprivation of liberty which are not covered by the MH(NI)O, 1986. When it is fully implemented the MCA(NI) 2016 will replace the MH(NI)O, 1986 for all interventions with everyone aged 16 and over who lacks the relevant decision making ability. Schedule 11 of the CVA 2020 introduces some possible temporary modifications to the MCA(NI) 2016 but again these are only to be used in the exceptional circumstances that the full requirements of MCA(NI) 2016 cannot be met.

Under MCA(NI) 2016 Health and Social Care Trust panels, made up of three members and held in person, can authorise interventions involving deprivation of liberty if the criteria are met. Schedule 11 of the CVA 2020 allows that these meetings may be held remotely and not all three members have to be present although all must at least provide a written opinion and the decision must be unanimous. The time limit for the Trust panel decision of seven working days can also be extended to 28 working days. The time limit for the effect of Trust panel interim authorisations can also be extended from 28 to 56 days.

Similar to modifications to the MH(NI)O, 1986, the MCA(NI), 2016 short term detention authorisations, which are only used for deprivation of liberty in hospital settings for up to 28 days, usually require the person to be seen within two days but Schedule 11 extends this to five days in an emergency. As part of the short term authorisation process the person's nominated person (as defined in s.69 of the MCA(NI) 2016) has to be consulted. If the nominated person objects to the short term detention, the requirement to consult an ASW, if doing so would involve an undesirable delay, has been extended to include the alternative of consulting a Relevant Social Worker.

There have also been some modifications to the Mental Capacity (Deprivation of Liberty) (No. 2) Regulations which essentially broaden the relevant health and social care professionals who can fulfill specific roles under the MCA(NI) 2016 from those who have completed the relevant, specific training, to all the specified professionals, except for those who are making applications for Trust Panel authorisation. The requirement that Trust Panels are made up of one medical practitioner,

one ASW and one suitably qualified person can also be modified to three suitably qualified professionals.

2.3. Social care law – potential changes to role, time limits and safeguards

For England and Wales section 15 CVA 2020 Schedule 12 Part 1 makes temporary revisions for the powers and duties to provide care and support under the Care Act 2014 (England) (CA 2014) and Part 2 for Authorities in Wales under the Social Services and Wellbeing (Wales) Act 2014 (SSW(W)A 2014). The provisions contained within Schedule 15 remove the necessity to comply with the usual duties to undertake an assessment of an adult, child or carer or young carers care and support needs or use the eligibility criteria to establish whether needs must be met. In addition, the Act provides that the duty to carry out a financial assessment can be disapplied. A local authority cannot charge for meeting any needs during this period, without having carried out an assessment under section 17 CA 2014 or section 63(2) of the SSW(W)A 2014. Importantly there are powers to charge retrospectively for care and support provided during the emergency.

In England, local authorities are placed under a duty to meet an adult's needs only if the authority considers that it is necessary to meet those needs for the purpose of avoiding a breach of the adult's human rights under the Human Rights Act 1998 (HRA 1998). The reference to avoiding any breach of a person's rights under the European Convention on Human Rights (ECHR) is an important reminder that in some cases a positive obligation to provide care and support will arise, albeit that a high threshold for such provision is applied by the courts. One of the best known cases where a positive obligation arose under Article 8 – in this case to provide adapted accommodation – was *R(Bernard) v Enfield Council* [2002]. This involved a husband and wife who had six children and the wife was severely disabled. The local authority had failed for some 20 months to provide adapted accommodation suitable to meet her needs. She was doubly incontinent and because there was no wheelchair access to the lavatory had been forced to defecate and urinate in the living room. She has also been unable to care properly for her children. In this case the court found a clear breach of the Article 8 right to a private and family life.

In Wales, the duty to meet an adult's needs in section 35 of the SSW(W)A 2014 has been amended to, in effect, remove the duty to meet needs that meet the eligibility criteria. Instead it provides that needs must be met if the local authority considers it necessary to meet them in order to protect the adult from abuse or neglect, or a risk of abuse or neglect.

Local authorities are also not required to comply with their duties to prepare care and support plans or support plans or review those plans, or include all the usual required information. CVA 2020 does not provide for any modifications to the adult safeguarding framework contained within the CA 2014 or the SSW(W)A 2014. In other words, these sections remain fully in force throughout the emergency period.

The modifications, also referred to as “easements”, to the CA 2014 were brought into force (from the 31 March 2020) by the CVA (Commencement No 2) Regulations 2020. These regulations should be read alongside the government's guidance on how to use the Care Act easements. In particular, the guidance sets out that while the easements (the Government's terms for the adjustment of legislative provisions to give greater flexibility, for the public sector, such as disapplying statutory duties and the extension or removal of legal time limits) to the provisions of the law took legal effect on 31 March 2020, they “should only be exercised by local authorities where this is essential in order to maintain the highest possible level of services. Local authorities should comply with the pre-amendment CA provisions and related care and support statutory guidance for as long and as far as possible”. The guidance also provides a step-by-step decision-making process that local authorities should follow in order to apply the easements and has also issued an Ethical Framework for Adult Social Care which is intended to ensure that ethical values and principles are applied to local

authority decisions to redirect resources and prioritise needs during the Covid-19 emergency. At the time of writing, only 8 local authorities in England have introduced the easements.

The modifications to the Social Services and Wellbeing (Wales) Act 2014 (SSW(W)A 2014) were brought into force (as from 1 April 2020) as a result of the Coronavirus Act 2020 (Commencement No 1) (Wales) Regulations 2020. However, this provides greater discretion to local authorities as the local authorities are left to interpret their responsibilities. These regulations should be read alongside the Welsh government's guidance on applying the modifications.

For Scotland, the Coronavirus Act 2020 (Commencement No. 1) (Scotland) Regulations 2020 brought into force on 5 April 2020 section 16 of the CVA 2020, which relates to a range of local authority duties and section 17, regarding guidance Scottish Ministers may provide. Principally, section 16 allows a local authority not to comply with statutory provisions relating to needs assessments for adults under section 12A of the Social Work (Scotland) Act, 1968 and assessments for children and young persons under sections 22, 23 and 29 of the Children (Scotland) Act, 1995. It also reduces requirements regarding adult carer support plans and young carer statements under sections 6 and 12 of the Carers (Scotland) Act, 2016 and general principles applicable to local authority functions in section 1 of the Social Care (Self-directed Support) (Scotland) Act 2013. In all instances, the modified measures may only be used if it would not be practical to comply with those provisions, or where to do so would cause unnecessary delay in providing services, support, advice, guidance and assistance. Local authorities must also have regard to any guidance provided under section 17. As with other jurisdictions, section 17 also prevents local authorities from charging for certain functions. The associated Scottish Government ‘Coronavirus (COVID 19): guidance on changes to social care assessments’ (Scottish Government, 2020b) refers local authorities to the same Ethical Framework for Adult Social Care indicated above and emphasises that the powers conferred in section 16 will only be switched on “when they are absolutely necessary to allow local authorities to prioritise and provide urgent care without delay” (p.4). Since commencement of the regulations on 5 April 2020 until 16 May 2020 Scottish Government reporting mechanisms recorded six Local Authorities using the powers; some applying them across all services, whereas others were using them on particular services only (Scottish Government, 2020a).

In Northern Ireland there were no changes to the existing statutory duties relating to the assessment of need and provision of health and social care. This raises the question of the necessity and purpose of making changes to these duties in the other jurisdictions.

2.4. Summary of emergency registration of the workforce, including final year students

CVA 2020, enables the emergency registration (which can be revoked) of specific health and social care professionals (sections 2–7, schedules 1–6) across the UK including nurses, doctors, social workers and, for Northern Ireland, allows pharmaceutical chemists prescribing powers. Emergency registration includes final year students. The register enables eligibility to return to work but is not compulsory. The usual registration bodies remain responsible for determining fitness to practise, and for the person being proper and suitable. Additionally, extra indemnification is offered across the UK (CVA 2020 section 11–13) to those offering a ‘health service’ from personal civil liability ‘in respect of or consequent on death, personal injury or loss, arising out of or in connection with a breach of a duty of care owed’, therefore offering secondary indemnification to staff. There is no mention of social care staff indemnification except in the Northern Ireland provisions.

Section 8, schedule 7 CVA 2020 makes provisions for emergency leave from a person's usual place of employment for volunteering for two to four weeks (unless excluded) if issued with an emergency

volunteering certificate from an appropriate authority such as county or local authority. The person will still maintain their usual substantive employment rights.

3. Discussion

This comparison of the respective changes to, mental health, capacity and social care legislation across UK jurisdictions raises numerous points, some of concern. For the purposes of this paper, discussion focuses on the following themes: process and scrutiny of legislative change; service provision; workforce; threat to human rights; and a wider concern about a lack of parity of esteem between social care and health care.

3.1. Process and scrutiny of legislative change

The process for amending health and social care legislation, particularly mental health, is well known within the UK for taking considerable time to progress through the constitutional and parliamentary processes. The amendments to the MHA 1983 in England and Wales through the enactment of the 2007 MHA as an example took in excess of seven years to achieve. In Northern Ireland the report recommending the MCA(NI) 2016 was published in 2007 and the MCA(NI) 2016 has not yet been fully implemented.

It was highly likely that CVA 2020 was drafted at breakneck speed when the potential significance of Covid-19 was becoming more apparent. Whereas legislation of that length and complexity would normally have taken many months to draft, it is possible that drafting only started in January/February. This would have left those undertaking this work barely a month in which to put together CVA 2020. Moreover, the process from Bill to Act took six days from 1st reading in Parliament on 19 March 2020, to gaining Royal assent on 25 March 2020, almost reinforcing the refrain, where there is a will there's a way. This was similar for CV(S)A 2020, which was introduced on 31 March 2020 and became law on 6 April 2020 and the CV(S)(No.2)A 2020, which was introduced on 11 May and became law on 26 May. The lack of Parliamentary scrutiny over this legislation has been a major source of concern. Furthermore, many of the specific changes in health and social care have been achieved by secondary legislation, such as regulations not subject to the full scrutiny of Parliament.

It is not to say that this approach was without risk also for the Government. Legislation drafted at such speed could contain a significant number of errors which may in turn lead to challenges to the legality of various aspects of it, along with the need for amendment. It is also possible that significant areas of policy were either not considered at all or at least not considered sufficiently. This may explain why, for example, the MCA 2005 did not feature at all in CVA 2020, even though it is recognised that legal provisions such as DoLS have become even more difficult to implement during the pandemic when government guidance prevents visits to hospitals and care homes, including by health and care professionals, except in exceptional circumstances. One of the consequences then of rapid introduction has been the increased significance of the use of government guidance as a tool for making changes to practice, which we also discuss further below.

However, the legal risks to the Government may be less significant than is portrayed. For instance, official opposition in the Westminster Parliament has been significantly reduced as a result of last year's general election; the willingness to take legal risks may be enhanced not just as a result of the need to respond swiftly and decisively to an international emergency, but on the basis that political challenge is unlikely. There may also have been a calculation that the courts are unlikely to be obstructive during such an emergency. The interpretation of the requirement in judicial review, that government actions must be rational and proportionate, may understandably be stretched in the current climate. The courts may prove to be more tolerant of modifications made to rights during an emergency, compared with 'normal

times'.

As a Government's mandate to legislate is often founded on low turnout for general elections, one key democratic and parliamentary process is the scrutiny by each stage of legislative process as well as public and professional consultation. This begs the question, when is exceptional, exceptional and who decides? Would those who receive services from the local government, such as mental health services, want to see their rights eroded to achieve administrative and professional ease? The answer is we don't know, as no such consultation has ever been undertaken or predictively planned for.

CVA 2020, CV(S)A 2020 and CV(S)(No.2)A 2020 have also been described as temporary, but how temporary is temporary? It is the case that the legislation could stay in place for up to two years, excepting Part 1 of CV(S)A 2020 and CV(S)(No.2)A 2020 which will automatically expires six months after they come into force, albeit they may be extended for two further periods of six months, giving a maximum duration of 18 months. Given the degree of concern that exists about the reduction in safeguards afforded in some instances by these statutes, how will these temporary provisions, should they be implemented, be scrutinised and monitored? This comparative analysis thus far points to considerable divergence in approach across the four countries and raises questions about effectiveness of this approach. Across the UK as summarised in Table 3, the scrutiny and monitoring of procedures prescribed in law to deprive a person of their liberty for reasons of 'unsoundness of mind' (Article 5 ECHR) varies. Does the suggested emergency legislation further dissipate this variation?

In addition, as well as there being different legislation across the four jurisdictions, the responsibility for scrutinising how in practice the implementation of the mental health legislation operates also varies. Scrutiny is important; how will the Government know that the provisions of CVA 2020, CV(S)A 2020 and CV(S)(No.2)A 2020 have been used appropriately and as intended. Table 4 sets out the usual scrutiny and quality assurance agencies, which may not be seen as robust enough when the legislation was unmodified at a time when even greater scrutiny is needed due to the easements.

It must be noted that many of the changes discussed in this paper have not yet been implemented. Only very minor changes to mental health legislation have been introduced in England and Wales, whilst, the changes to adult social care have, at the time of writing, only been implemented by eight local authorities in England. This raises the question of whether they were necessary in the first place: some of these changes have been introduced and have been achieved without specific emergency legislation. The courts in England and Wales, for example, have managed to adapt their process to cope with the pandemic whilst practice directions and guidance have enabled the expansion of virtual hearings and capacity assessments to take place using online platforms. In Scotland, as indicated, significant changes relating to incapacity have been implemented, while others have thus far not come into force. The changes to social care needs assessments, at the time of writing, have been used by six local authorities. In Northern Ireland, Schedule 10 and most of Schedule 11 of the CVA 2020 did come into force on 2nd April 2020 but are only to be used if necessary and there have been no changes to duties to assess need and provide services.

A check has been applied to the modifications of adult social care provision through the use of statutory guidance. In England CA 2014 easement guidance provides that local authorities should only apply the easements as a last resort and in accordance with a four stage decision making process, which places the Principal Social Worker at the centre. Likewise, Scottish Government guidance emphasises that the changes to social care will not happen unless "absolutely necessary" to enable local authorities to provide urgent care without delay. The use of non-statutory guidance, rather than CVA 2020, has been essential in encouraging a flexible approach to MCA 2015 and DoLS in England and Wales, including remote assessments of capacity and triaging deprivation of liberty cases. Arguably, changes of such significance in human rights terms should have a statutory basis. However, one of the key

developments in government policy making has been the expanded use of guidance.

3.2. Workforce

During times of national emergency it can be anticipated that reserve workforces will be needed as observed throughout UK history, in multiple spheres of public and civic functions. During the current national Covid-19 emergency this has been seen in a number of ways, not least:

- Through the National Health Service COVID-19 pandemic volunteering scheme;
- Through easements for doctors under mental health legislation;
- Through the provision for the emergency, albeit temporary registration of returning and nearly qualified professionals;
- Creation of new roles in Northern Ireland in respect of the 'relevant social worker' and the 'relevant medical practitioner'.

In relation to mental health law modifications and doctors, it is noticeable from reviewing the parliamentary debates (Handard 2020, 2020a, 2020b) that there was a clear intention to ease the burden on doctors under mental health legislation. Through reducing the need for two doctors to one when justification could be made (see Table 1 above). This easement was supported by the Royal College of Psychiatrists and deemed "necessary to protect people with serious mental health problems and to ensure rapid access to treatment" by *Baroness Watkins of Tavistock* (Hansard, 2020b).

Such easement is curious on some levels when you consider the usual availability of doctors compared to other professionals who are registered for example in England as shown in Table 5:

Although the figures in Table Error! Reference source not found. are not from 2020, the proportions are likely to be similar today. It is clear to see that the AMHP workforce (without whom no civil detention can be made other than the Nearest Relative of England are far fewer in number, and yet there has been no easement for this workforce at all in England in either primary or secondary legislation. Although, legally the Nearest Relative (NR) could complete the application there is equally no compensatory measure for NRs who are unable to fulfill their function due to increased likelihood of sickness. Furthermore, as the NR role is arguably there to offer additional safeguards to comply with Article 5 ECHR the lack of such provisions is also concerning. Arguably, this lack of consideration is a concern, as we are more likely to see a depleted AMHP workforce before doctors. An absence of NR provision might also see a potential loss in safeguards. Interestingly to some degree this has been considered in Northern Ireland with the introduction of a new role entitled the 'relevant social worker' as described above, who can act when an ASW is not available. This new role is also accompanied by the 'relevant medical practitioner' when the 'approved doctor' can not be involved. In Scotland, the changes introduced to capacity legislation have eased some MHO functions, for example, regarding renewals of Guardianship Orders.

Reducing the number of doctors was also seen a concerning move by parliamentarians (Hansard, 2020c) as Viscount Hanworth in the House of Lords is quoted as saying:

"Sectioning a person under the Mental Health Act can injure a person for a lifetime. Therefore, I wish to sound a note of caution, if not alarm, at the provisions in Schedule 8 to the Bill".

Under CVA 2020 if implemented, a doctor who does not know the service user and an AMHP could deprive a person of their liberty; not only is the doctor's role eased, but also the method of detaining a person also is. Concern over the amendments to the mental health legislation is well represented in the debates.

CVA 2020 introduced the possibility for the emergency registration of nurses, social workers, medics and other health and care professions

arguably in case perceived workforce shortages were realised. There was clear intention to ensure that all health and social care roles were covered. However, in England and Wales no provision has been made for AMHP trainees to gain emergency approval to practice which is in contrast to the arrangements in Northern Ireland for the current ASW trainees to be approved. Arrangements in Scotland have focused on enabling MHO trainees to qualify as soon as possible, allowing easing of some educational requirements where necessary. However, the fundamental matter remains: can the public be reassured that the re-recruited, provisionally registered and newly created professional roles have been assessed as competent to undertake the role and can give them confidence in their safety to practise? Equally, due regard needs to be given to the health and wellbeing of the workforce overall. One such example is from the British Association of Social Workers (BASW), the professional body that covers all four nations, who have suggested that as workers will undoubtedly be delivering services in unusual circumstances this will create stress and tension, which could ultimately impact negatively on decision-making (BASW, 2020).

Finally, given the social distancing refrain and requirement for all, it is a surprise that to enable the workforce to undertake their work, provisions were not made consistently across the four countries for electronic forms, signatures and video assessments. For example, in Scotland, assessments by telephone or video call are permitted where required. Existing practice meant that an MHO's application for a CTO form did not require to be signed by the MHO if it came from a secure email address and this is now extended to allow other statutory forms to be sent from professional staff using a secure email address, without a signature. In contrast, in England and Wales, currently, it is unclear as to whether a digital signature on a detention paperwork would be accepted as lawful by the hospital managers, and the ethics, including right to privacy, of undertaking assessment at distance through the use of online platforms are still to be explored.

Alternatively, provisions have been made to adjust time scales for professionals to respond, and the amount of time a person can be held for. The length of the various time scales under mental health legislation are arbitrary in any event, as there is no evidence to suggest why they are the lengths they are originally (such as 28 days or 3 months). Efficiency could have been gained by enabling staff to undertake their roles under the legislation at a distance by using electronic means which some professionals have been using in any event due to necessity, but being concerned as to their legality nonetheless. To some extent this has been confirmed by the legal guidance issued by NHS England (NHS England, 2020).

How the changes are implemented to the constitution of the mental health tribunal may also have significant implications for the process of reviewing the ongoing necessity of the detention. In England, for example, there is the possibility of single member panels which would need to be a legally qualified professional. There is also the possibility of panels consisting of two members in some cases. This raises the question of who will be "missing" from the panel. It is highly likely that the lay perspective will be the most vulnerable in this context, which would mean that the user perspective or the social care perspective of a practitioner would be lost. This may impact on the outcome of decisions and perhaps also the quality of the decisions. On the other hand, it might be argued that the civil court system is based on the assumption of a single judicial decision maker who is able to take expert evidence from anyone including service users and professionals. The Court of Protection in England and Wales provides a classic example of how the courts would normally operate in this way. What is clearly missing however is a pluralist approach to decision making that can occur in tribunals, albeit that there is little conclusive evidence on the merits of this approach.

3.3. Threat to human rights

The COVID-19 pandemic presents a unique challenge to human

rights. This was clearly evident in the June 2020 report by the Joint Committee on Human Rights, “Human Rights and the Government’s response to Covid 19 the detention of young people who are autistic and/or have learning disabilities” (JCHR, 2020). This found that the coronavirus emergency has resulted in human rights abuses for many young people with autism and/or learning disabilities through unlawful blanket bans on visits, the suspension of routine inspections, increased use of restraint and solitary confinement, and the vulnerability of those in detention to infection with Covid19.

In the face of these concerns, it is important to recognise that the HRA continues to apply. This means that all public authorities must act in accordance with the ECHR rights. All legislation must include a statement by the relevant minister setting out their view that the provisions of the Bill are compatible with those ECHR rights or that they are unable to make such a statement but wish to proceed with the Bill. All UK legislation must be read and given effect as far as possible in a way which is compatible with the ECHR articles that are contained in the HRA. The courts can issue a statement of incompatibility where a provision is incompatible with one of those ECHR rights and can in some cases quash or declare invalid subordinate legislation.

To some degree what counts as ECHR compatible can be seen as a matter of interpretation by our domestic and the European Court of Human Rights (ECtHR). It may be the case that the courts will be more sympathetic to the Government given the unprecedented emergency that it is facing. The UK Government will no doubt argue robustly that the emergency and temporary amendments introduced through CVA 2020, CV(S)A 2020, CV(S)(No.2)A 2020 and accompanying regulations and guidance are essential during a time of emergency. But equally, the courts may view its role as to serve as a check on government and ensuring that human rights are at the centre of the response to the public emergency.

The UK Government does have the legal means to ‘disapply’ specific provisions of the ECHR. Article 15 ECHR permits derogation from the obligations under the ECHR (including those arising from Articles 5 and 8) in certain situations. This includes during public emergencies which threaten the life of the nation. At the time of writing no notification of any derogation of any such right has been made; although the Vice President of the Court of Protection in England and Wales has commented that the pandemic does amount to a “public emergency” for the purposes of Article 15 which had established “a solid foundation upon which a derogation becomes not merely justified but essential” (BP v Surrey CC [2020] EWCOP).

A formal derogation would no doubt prove politically contentious, but it may ultimately be unnecessary. Many ECHR rights are flexible and allow the specific circumstances of the pandemic to be recognised. For example, Article 8(1) is a qualified right, and state interferences with the various aspects of the right are permitted where they are in accordance with the law and necessary in a democratic society in the interests of, for example, the protection of health. In addition, there can often be a high threshold before some ECHR rights will be breached, such as Article 2 (the right to life).

It is also worth noting that the ECHR does not guarantee many of the provisions which have been “eased” by CVA 2020. For example, Article 5 does not guarantee any right to two medical opinions, a second medical opinion or a doctor with previous acquaintance. The CVA 2020 can therefore be described as temporarily reducing safeguards in the space of human rights but may not in formal legal terms be incompatible in formal legal terms and is not incompatible with ECHR.

This may mean that the courts increasingly turn to the UN Convention on the Rights of Persons with Disabilities (CRPD), which was ratified by the UK in 2009, to protect individual rights. While not directly incorporated into our domestic law, the CRPD is applied by the courts as an aid to interpretation of ECHR. Article 11 (situations of risk and humanitarian emergencies) of the CRPD provides that: “States Parties shall take, in accordance with their obligations under

international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.” Additionally, Article 25 of the CRPD emphasises the right of people with disabilities to the highest attainable standard of health without discrimination on the basis of disability.

An early indication of how the court might respond to the COVID-19 emergency was provided in BP v Surrey CC [2020] EWCOP¹ 17. In his decision, Mr. Justice Hayden commented that the pandemic plainly falls within the circumstances contemplated by Article 11 of the CRPD and “signals the obligation on the Courts, in particular, and society more generally, to hold fast to maintaining a human rights based approach to people with disabilities when seeking to regulate the impact of this unprecedented public health emergency”. For example, the government’s decision to suspend care home visits will often have a seismic impact on the quality of life of older and disabled people. There is a commensurate need for health and social care professionals to ensure that fundamental rights are not eclipsed by the urgent demands of the coronavirus pandemic. This is exemplified by the proposed changes to S13ZA in Scotland. S13ZA was already a controversial measure, as arguably it does not provide a sufficiently protective legal framework for substitute decision making. The removal of the requirement to take account of the adult’s and others’ views and to ensure they are not in disagreement with the proposed care plan, should they be implemented, leaves open the potential for some very worrying outcomes; such as adults being moved from home or hospital and placed in care facilities against their wishes. Why such safeguards should be removed from someone who is subject to capacity rather than mental health legislation is not made clear. A likely motivation was to free-up beds in acute hospital wards, raising questions about the extent to which fundamental rights can be modified to account for structural problems in the health and social care system.

3.4. Social care and health care

The initial public and political consciousness of the impact of Covid-19 on social care seemed to be very low at the outset. Concerns about deaths in care, nursing and residential units were unrepresented in government statistics and there was uncertainty as to whether these same facilities were getting the necessary personal protective equipment (PPE). Equally, there appeared to be a lack of understanding about the relative importance of social care during the pandemic, such as family carers being unable to access respite. Such an omission perhaps reasserts the importance of citizen involvement in these processes, including in crisis planning at local and Government level. Covid-19 has highlighted and exacerbated existing inequities in society including the differences between the approaches to health care and social care. The current increased awareness and understanding of the importance of social care, and the consequences of neglecting it, have perhaps created an opportunity to introduce funding arrangements which reflect a parity of esteem and priority between health and social care and do not discriminate against people based on whether their needs are health care or social care related. It has also raised the possibility of addressing some of the more fundamental inequities in society including issues of poverty and discrimination based on ethnicity, disability and age. It is often said that necessity is the mother of invention; it will be interesting to see what, if any, new policies and practices emerge. In addition to the positive potential of the current context to address societal inequities it will also be important to examine whether any of the emerging policies and practices may be of concern. The notion that the Covid-19 virus or any virus does not discriminate has been challenged. The Office of National Statistics (ONS) has highlighted that:

¹ England & Wales Court of Protection

'In England, the age-standardised mortality rate of deaths involving COVID-19 in the most deprived areas was 128.3 deaths per 100,000 population; this was more than double the mortality rate in the least deprived areas (58.8 deaths per 100,000)'.

'The most deprived areas in Wales had a mortality rate for deaths involving COVID-19 of 109.5 deaths per 100,000 population, nearly twice as high as in the least deprived areas (57.5 deaths per 100,000 population)' (ONS, 2020)

Similar findings have been published by [National Records of Scotland \(2020\)](#) which show that people living in the most deprived areas of Scotland were 2.3 times more likely to die with COVID-19 than those living in the least deprived areas. This is in slight contrast to Northern Ireland where there has been a small increase in Covid-19 cases for the *least* deprived areas ([Public Health Agency, 2020](#)).

The [ONS \(2020\)](#) acknowledges that mortality rates are usually higher in areas of deprivation in any event, however suggests that Covid-19 is increasing this ([ONS, 2020](#)). It has been observed freely that the most vulnerable and structurally disadvantaged in society are overall disproportionately impacted by Covid-19.

3.5. Shifting thresholds

There are examples throughout CVA 2020, the CV(S)A 2020 and the CV(S)(No.2)A 2020 of a shifting of thresholds. These include the following:

- To demonstrate competence as a returning or final year professional student;
- To protect themselves (the professional) from liability through indemnification;
- To provide, or not, care and support by local authority bodies;
- The number of doctors required to make a medical recommendation that a person's liberty is removed;
- The professional attributes and training of those same doctors;
- The length of time a person can be held, pending an assessment.

Although these shifting thresholds are deemed to be temporary even if implemented, a 'new normal' may emerge the longer the measures are in place. The rationale for modifying the duties contained within the respective social care legislation may not be seen as a concern for those not needing them. However, can the rationale for modifying them in the first place be sufficiently justified in the local authority areas where they have been implemented in an environment whereby most things can be justified during 'unprecedented' times'.

The emergency amendments to legislation hold significant implications for people who experience mental health problems. At the present time, a lack of statistical information makes it difficult to chart the impact of these changes with accuracy. Nonetheless, there are obvious concerns about the potential of any reduction in the provision of services by health and social care agencies. This potential arises from a number of factors, including the removal of duties on local authorities (in force England & Wales and Scotland) to assess adults, children, carers or young carers and to meet needs or use eligibility criteria to establish whether needs can be met. There are also problems related to accessing services, influenced by measures including social distancing and the priority given to treating in hospital those with Covid-19. It is likely that this has resulted in people feeling unable or dissuaded from accessing mental health services.

Importantly, these access issues are predicted to be exacerbated by a rise in mental health problems due to Covid-19, as conveyed in a recent paper in the *Lancet* (Holmes and Connor et al., 2020). Utilising two surveys of people with lived experience and international research evidence and expertise, it revealed widespread concerns about increased depression, stress, anxiety and other negative feelings as well as

a spiralling of pre-existing mental health conditions. Of particular note was a predicted rise in suicide and self-harm, albeit this was viewed as not inevitable, if adequate "national mitigation efforts" (p.2) are made. Moreover, the surveys revealed significant worries about the impact of financial precarity resulting from Covid-19, correlating with established causal links between increased unemployment, financial insecurity and poverty and poorer mental health. The authors called for urgent and coordinated research to develop approaches to mitigate the damage to people's mental health. This reflects other calls for a 'wellbeing task-force', to be established in the UK to share knowledge between communities, voluntary groups and professionals of effective approaches towards reducing the effects of bereavement and isolation ([BASW, 2020](#)). Given this context, the easement of social care service provision, as discussed above, may contribute to a worsening of mental health and potentially, for some, with fatal consequences.

What the future of health and social care provisions will look like post the pandemic remains to be seen. What is clear is that a balance is needed between the perceived increase in demand for health and social care services and a potential workforce shortage with maintaining the rights and safeguards towards the most vulnerable in our society. Whether this has been achieved only time will tell, but the concerns above need to be answered.

The emergency measures are temporary but can be extended, which raises the question how temporary is temporary? What will be interesting is the lessons that can be learned from the successes or failures of their implementation and what new form of normal will emerge. For example, if mental health detentions have been successfully undertaken without challenge then perhaps this work will see less doctors in attendance, overturning the established view of 'objective medical opinion' as needing to be provided by two medics.'

4. Conclusion

This article set out to summarise and compare the relevant changes, or potential changes, to mental health, mental capacity and adult social care law across the four jurisdictions of the UK. In our discussion of the possible impact of these, several core themes emerged: concerns around process and scrutiny; concerns about possible changes to the workforce and last, the possible threat on the ability to safeguard human rights. It has been shown that, ordinarily, legislative provisions across the jurisdictions of the UK are different, save for Wales (which shares most of its mental health law provisions with England). Such divergence is also mirrored in the way in which the suggested emergency changes could be implemented. Aside from this, there is also a wider concern about a lack of parity of esteem between social care and health care, a concern which is common to all. What is interesting is that the introduction of CVA 2020 forced a comparison to be made between the four UK nations which also shines a spotlight on how citizens can anticipate receipt of services. The reality is that the ECHR may not offer the protections that the public and professionals perceive. If they did the legislative provisions contained within CVA 2020, CV(S)A 2020 and CV(S)(No.2)A 2020 would already have been deemed incompatible with those provisions we have discussed. Instead, the safeguards need to be seen as augmenting the Government's interpretation of ECHR Articles. Any safeguard which would have come through lobbying and campaigning processes by citizens, including those with lived experience, has been very limited on this occasion. As [Kelly \(2020\)](#) has highlighted in relation to the Republic of Ireland, the proportionality of these temporary modifications will also depend on how they are implemented in practice. Equally, we share this perspective as the question remains in this article as to whether the legal provisions are proportionate, necessary and can be justified if and where used.

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